OFFICE OF THE SECRETARY OF STATE
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ARCHIVES DIVISION
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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED
09/25/2023 4:11 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Update All Payer All Claims claims files

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/23/2023 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Pete Edlund
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/18/2023
TIME: 11:05 AM - 11:30 AM
OFFICER: Pete Edlund

REMOTE MEETING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1601737397
SPECIAL INSTRUCTIONS:
Meeting ID: 160 173 7397
Passcode: 022062

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Meeting ID: 160 173 7397

Find your local number: https://www.zoomgov.com/u/ab5m7ZEijN

NEED FOR THE RULE(S)

APAC is updating rules and items collected to better meet OHA's data needs

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The program does not interact with individuals, providers or community groups. The All Payer All Claims program does not establish eligibility for coverage, determine services to be provided or establish the cost or payment for any services. The program receives administrative data from insurers, third party administrators, pharmacy benefit managers and other insurer-types on services provided including to whom, service, service provider, billed amount and paid amount.

The program continues to work with the Equity and Inclusion Division for guidance on how to work with community groups to determine the best way to acknowledge and document the structural racism underlying data received to mitigate propagating inequities in the guise of quantitative unbiased data.

FISCAL AND ECONOMIC IMPACT:

Meeting attendees did not voice and no comments have been received indicating an economic impact from these rule changes

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). None
(2) Effect on Small Businesses: None known
(a) Estimate the number and type of small businesses subject to the rule(s); Zero
(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); None
(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s). No reporting requirements due to change in rules anticipated for small businesses.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses are not affected by these rule changes.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

409-025-0120, 409-025-0140, 409-025-0160

AMEND: 409-025-0120

RULE SUMMARY: File layout changes and clarifications

CHANGES TO RULE:

409-025-0120
Data File Layout, Format, and Coding Requirements ¶

(1) All mandatory reporters shall submit claims-based data for all claims where the subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the State of Oregon is the payer.¶
(2) Claims-based data files shall include:¶
(a) Enrollment;¶
(b) Medical claims;¶
(c) Pharmacy claims;¶
(d) Dental claims;¶
(e) Provider;¶
(f) Subscriber-billed premiums; and¶
(g) Control totals files.¶
(3) Mandatory reporters must include plan-specific identifiers for members, subscribers, providers and contracts in required files. Mandatory reporters authorized by the Centers for Medicare and Medicaid Services or contracted through an insurer must provide the member's identifier for those organizations in addition to the mandatory reporters' member specific identifier. All identifiers must be:¶
(a) Sufficient length to be unique within the mandatory reporters' solution;¶
(b) Assigned to a single individual, entity or contract;¶
(c) Consistent across all files for the submission; and¶
(d) Persistent over time unless change in identifier is required due to change in coverage or contract.¶
(4) The enrollment file shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix A, Enrollment.¶
(a) Mandatory reporters shall report race and ethnicity data as outlined in Appendix A, Enrollment. This layout aligns with the Office of Management and Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-58790).¶
(b) Mandatory reporters shall report primary language in accordance with ANSI/NISO guidance using the three-character string outlined in Codes for the Representation of Languages for Information Interchange.¶
(c) Race, ethnicity and primary language data shall be collected in a manner that aligns with the following principles:¶
(A) To the greatest extent practicable, race, ethnicity, and preferred language shall be self-reported.¶
(i) Collectors of race, ethnicity and primary language data may not assume or judge ethnic and racial identity or preferred signed, written and spoken language, without asking the individual.¶
(ii) If an individual is unable to self-report and a family member, advocate, or authorized representative is unable to report on his or her behalf, the information shall be recorded as unknown.¶
(B) When an individual declines to identify race, ethnicity or preferred language, the information shall be reported as refused.¶
(5) The membership total and claims control files shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix G, Membership Total and Claims Control.¶
(6) The subscriber-billed premium file shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix F, Subscriber-Billed Premium.¶
(7) The provider file shall be submitted by all mandatory reporters other than PBMs and CCOs using the approved layout, format, and coding described in Appendix E, Provider.¶
(8) The medical claims file shall be submitted by all mandatory reporters other than PBMs, CCOs, and dental carriers using the approved layout, format, and coding described in Appendix B, Medical Claims.¶
(9) The pharmacy claims file shall be submitted by PBMs and carriers using the approved layout, format, and coding described in Appendix C, Pharmacy Claims.¶
(10) The dental claims file shall be submitted by all mandatory reporters other than PBMs and CCOs who provide dental coverage using the approved layout, format, and coding described in Appendix D, Dental Claims.¶
(11) All data elements are required unless specified as optional or situational within the file layout.¶
(12) All required data files shall be submitted as delimited ASCII files.¶
(13) Numeric data are positive integers unless otherwise specified.¶

(a) Negative values are allowed for quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.¶
(b) Negative values shall be preceded by a minus sign.¶
(14) All data files shall pass edit checks and validations implemented by the Authority or the Authority's data vendor.¶
(a) Data vendors may perform quality and edit checks on data file submissions. If data files do not pass data vendor edit checks or validation, mandatory reporters must make corrections and resubmit data. Mandatory reporters must submit corrected data that passes all quality and edit checks or receive an approved exemption within 14 calendar days of notification by the Authority or the Authority's data vendor of the error.¶
(b) Mandatory reporters must participate in efforts to validate and check the quality of current and historic APAC data, as prescribed and requested by the Authority.¶
(A) The Authority may request from mandatory reporter's information from their internal records that is reasonably necessary to validate and check the quality of APAC data. This information may include, but is not limited to, aggregated number of enrolled members, number of claims and claim lines, charges, allowed amounts, paid amounts, co-insurance, co-payments, premiums, number of visits to primary care, emergency department, inpatient, and other health care treatment settings, and number of prescriptions.¶
(B) Mandatory reporters shall provide the aggregated information within 30 days of the Authority's request.¶
(C) If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or receive an approved extension or exemption within 30 days or at the next regularly scheduled submission due date.
Statutory/Other Authority: ORS 442.~~466~~373
Statutes/Other Implemented: ORS 442.~~464,~~373, ORS 442.~~466~~372

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Claims data files must include data for all claims where the subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the State of Oregon is the payer. OAR 409-025-0120

Appendix A: Enrollment

All Mandatory Reporters must submit this file. OHA acts as the data submitter for CCOs by contract.

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME001	Payer type	Text	1	Yes	See lookup table ME001	0.0%
ME003	Product code	Text	4	Yes	See lookup table ME003	0.0%
ME004A	Eligibility date	Date	8	Yes	CCYYMMDD (example 20200501) Dates before the submission date range are not valid. See Schedule A for submission date range	0.0%
ME005A	Termination date	Date	8	Yes	CCYYMMDD Use 99991231 if termination date is open-ended	0.0%
ME007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber; this identifier value should be consistent between files and over time	1.2%
ME009	Plan specific contract number	Text	30	Yes	Plan specific contract number, AKA group number	1.2%
ME009A	PEBB flag	Numeric	1	Yes	Public Employees Benefits Board Valid values: 1 (PEBB group) 0 (otherwise)	0.0%
ME009B	OEBB flag	Numeric	1	Yes	Oregon Educators Benefits Board Valid values: 1 (OEBB group) 0 (otherwise)	0.0%
ME009C	Medical home flag	Numeric	1	Situational	Valid values: 1 (Medical home plan) 0 (otherwise) Not required when ME001 = E (Dental)	0.0%
ME010	Member ID	Text	30	Yes	Plan-specific unique identifier for member; this identifier value should be consistent between files and over time	0.0%
ME012	Relationship code	Numeric	2	Yes	See lookup table ME012	1.2%
ME013	Member sex	Text	1	Yes	Valid values: M (male) F (female) and U (unknown)	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME014	Member date of birth	Date	8	Yes	CCYYMMDD (example: 19570402) Leave blank if unavailable	1.2%
ME015A	Member’s street address	Text	50	Yes	Member’s primary street address. If member’s address is missing, default to subscriber’s address. Format: street number pre-directional street name street designator post-directional Example: 123 N Main Street	1.2%
ME015	Member city	Text	30	Yes	Example: Grants Pass	1.2%
ME016	Member state	Text	4	Yes	Example: OR	1.2%
ME017	Member ZIP	Text	10	Yes	Example: 97209-1234 or 97209	1.2%
ME018	Medical coverage flag	Text	1	Situational	Valid values: Y (yes) or N (no). Not required when ME001 = E.	0.0%
ME019	Prescription drug coverage flag	Text	1	Situational	Valid values: Y (yes) or N (no). Not required when ME001 = E.	0.0%
ME101	Subscriber last name	Text	35	Yes		1.2%
ME102	Subscriber first name	Text	25	Yes		1.2%
ME103	Subscriber middle name	Text	25	Situational	Populate if available.	N/A
ME104	Member last name	Text	35	Yes		1.2%
ME105	Member first name	Text	25	Yes		1.2%
ME106	Member middle name	Text	25	Situational	Populate if available.	N/A
QC013					Do not populate; blank/null required.	0.0%
QC014					Do not populate; blank/null required.	0.0%
QC015					Do not populate; blank/null required.	0.0%
QC016					Do not populate; blank/null required.	0.0%
QC017					Do not populate; blank/null required.	0.0%
QC018					Do not populate; blank/null required.	0.0%
QC019					Do not populate; blank/null required.	0.0%
QC020					Do not populate; blank/null required.	0.0%
RE1	Member race	Text	1	Yes	See lookup table RE1.	1.2%
RE2	Member ethnicity	Text	1	Yes	See lookup table RE2.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
RE3	Primary spoken language	Text	3	Yes	See lookup table RE3.	1.2%
OHLC3					Do not populate; blank/null required.	0.0%
OHLC4					Do not populate; blank/null required.	0.0%
OHLC5					Do not populate; blank/null required.	0.0%
OHLC6					Do not populate; blank/null required.	0.0%
OHLC7					Do not populate; blank/null required.	0.0%
ME009D	OMIP flag	Numeric	1	Yes	Valid values: 1 (OMIP member), 0 (otherwise)	1.2%
ME009E	HKC flag	Numeric	1	Yes	Valid values: 1 (Healthy Kids Connect plan), 0 (otherwise)	1.2%
ME201	Medicare coverage flag	Text	2	Situational	Type of Medicare coverage. Valid values: A (Part A), B (Part B), AB (Parts A and B), C (Part C only), D (Part D only), CD (Parts C and D), X (other), Z (none). Not required when ME001 = E.	1.2%
ME202	Market segment	Text	2	Yes	See lookup table ME202.	0.0%
ME203	Metal Tier	Text	1	Situational	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements. Valid values: 0 (Not a QHP or catastrophic plan), 1 (Catastrophic), 2 (Bronze), 3 (Silver), 4 (Gold), 5 (Platinum). Not required when ME001 = E.	0.0%
ME204	HIOS Plan ID	Text	14	Situational	Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If plan is not a QHP under the ACA, enter 99999999999999. Not required when ME001 = E.	0.0%
ME205	High Deductible Health Plan Flag	Text	1	Yes	Valid values: Y (policy meets IRS definition of HDHP), N (policy does not meet IRS definition of HDHP)	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME206	Primary Insurance Indicator	Text	1	Yes	Valid values: Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y.	0.0%
ME207	Dental Coverage Flag	Text	1	Situational	Valid values: Y (member had dental coverage in this period), N (member did not have dental coverage in this period). Blank unless ME001 = E.	1.2%
ME208	Additional member identifier	Text	30	Yes	Member level unique identifier received from contracting organization for the member; If coverage is associated with Medicare, value should be the Medicare Beneficiary Identification; for Third Party Administrators and Pharmacy Benefit Managers contracting with insurer or employer, value should be unique member identifier received from insurer or employer	5.0%
ME209					For future implementation	NA
ME210					For future implementation	NA

File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_enrollment_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_enrollment_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_enrollment__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between 'dental_enrollment' and <quarter>.

Example: OMIP_OMIP_dental_enrollment__2015Q2_20150521_010101.dat

Lookup Table ME001: Payer Type

This field contains a single letter identifying the payer type.

Code	Value
C	Carrier
D	Medicaid
G	Other government agency
P	Pharmacy benefits manager
T	Third party administrator
U	Unlicensed entity
E	Dental

Lookup Table ME003: Product Code

This field contain the insurance type or product code that indicates the type of insurance coverage the individual has.

Code	Value
MDE	Medicaid dual eligible HMO
MD	Medicaid disabled HMO
MLI	Medicaid low-income HMO
MRB	Medicaid restricted benefit HMO
MR	Medicare Advantage HMO
MP	Medicare Advantage PPO
MPD	Medicare Part D only*
MC	Medicare Cost
PPO	Commercial PPO
POS	Commercial POS
HMO	Commercial HMO
SN1	Special needs plan – chronic condition
SN2	Special needs plan – institutionalized
SN3	Special needs plan – dual eligible
CHP	Special Children's Health Insurance program (SCHIP)
MDF	Medicaid fee-for-service
SIP	Self-insured PPO
SIF	Self-insured POS
SIH	Self-insured HMO
PH	Pharmacy benefits only*
IN	Commercial Indemnity
EPO	Commercial EPO
SL	Commercial stop loss
DPPO	Dental PPO
DPOS	Dental POS
DHMO	Dental HMO
DSIP	Dental self-insured PPO
DSIF	Dental self-insured POS
DSIH	Dental self-insured HMO

* **Please note** that codes 'PH' and 'MPD' must be used in conjunction with the appropriate lines of business. 'PH' should be used for Commercial lines of business only, while 'MPD' should be used for Medicare membership only.

Lookup Table ME012: Relationship code

This field contains the member's relationship to the subscriber or the insured.

Code	Value
1	Spouse
4	Grandfather or Grandmother
5	Grandson or Granddaughter
7	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner

Lookup Table RE1

This field contains a single letter identifying the member's race.

Code	Value
A	Asian
B	Black or African American
I	American Indian or Alaska Native
P	Native Hawaiian or Pacific Islander
W	White
O	Other (or multiple races)
R	Refused
U	Unknown

Lookup Table RE2

This field contains a single letter identifying the member's ethnicity.

Code	Value
H	Hispanic
O	Not Hispanic
R	Refused
U	Unknown

Lookup Table RE3

This field contains the ANSI/NISO three-character string identifying the member's primary spoken language. Please refer to most recent version of ANSI/NISO Z39.53 (Codes for the Representation of Languages for Information Interchange); the 2001 version is freely available here: https://groups.niso.org/apps/group_public/download.php/6541/.

Lookup Table ME202

This field contains an integer indicating the market segment.

Code	Value
1	Policies sold and issued directly to individuals (non-group) inside exchange
2	Policies sold and issued directly to individuals (non-group) outside exchange
3	Policies sold and issued directly to employers having 50 or fewer employees inside exchange
4	Policies sold and issued directly to employers having 50 or fewer employees outside the exchange
5	Policies sold and issued directly to employers having 51 to 100 employees inside exchange
6	Policies sold and issued directly to employers having 51 to 100 employees outside the exchange
7	Policies sold and issued directly to employers having 100 or more employees
8	Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has purchased stop-loss or group excess insurance coverage
9	Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has not purchased stop-loss or group excess insurance coverage
10	Associations/Trusts and Multiple Employer Welfare Arrangements (MEWAs)
11	Other

Appendix B: Medical Claims file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC001	Payer type	Text	1	Yes	See lookup table ME001 (in Eligibility file)	0.0%
MC003	Product code	Text	4	Yes	See lookup table ME003 (in Eligibility file)	0.0%
MC004	Claim ID	Text	80	Yes	Payer's unique claim identifier	0.0%
MC005	Service line counter	Numeric	4	Yes	Increments of 1 for each claim line	0.0%
MC010	Member ID	Text	30	Yes	Plan-specific unique member identifier; this identifier value should be consistent between files and over time	0.0%
MC017	Payment date	Date	8	Situational	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only	0.0%
MC018	Admission date	Date	8	Situational	CCYYMMDD (example: 20090624). Required only for institutional claims	1.2%
MC023	Discharge status	Text	2	Situational	See lookup table MC023. Required only for institutional claims	1.2%
MC024	Rendering provider ID	Text	30	Yes	Identifier for the rendering provider as assigned by the reporting entity	1.2%
MC036	Type of bill	Numeric	3	Situational	See lookup table MC036. Required only for institutional claims	1.2%
MC037	Place of service	Text	2	Situational	See lookup table MC037. Required only for professional claims	1.2%
MC038	Claim status	Text	1	Yes	Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%
MC038A	COB status	Text	1	Yes	Was claim a COB claim? Valid values: Y (yes), N (no)	1.2%
MC041	Principal diagnosis	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC041P	POA flag 1	Text	1	Situational	Present on admission flag for principal diagnosis. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC042	Diagnosis 2	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC042P	POA flag 2	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC043	Diagnosis 3	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC043P	POA flag 3	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC044	Diagnosis 4	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC044P	POA flag 4	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC045	Diagnosis 5	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC045P	POA flag 5	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC046	Diagnosis 6	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC046P	POA flag 6	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC047	Diagnosis 7	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC047P	POA flag 7	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC048	Diagnosis 8	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC048P	POA flag 8	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC049	Diagnosis 9	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC049P	POA flag 9	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC050	Diagnosis 10	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC050P	POA flag 10	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC051	Diagnosis 11	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC051P	POA flag 11	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC052	Diagnosis 12	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC052P	POA flag 12	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC053	Diagnosis 13	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC053P	POA flag 13	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC054	Revenue code	Text	4	Situational	Include all digits (example:0320). Required only for institutional claims.	1.2%
MC055	CPT/CPT II/HCPCS/ HIPPS Procedure code	Text	5	Yes	CPT. CPT II, HCPCS or HIPPS code. Include all digits (examples: 29870 or G0289)	1.2%
MC056	Procedure modifier 1	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057	Procedure modifier 2	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057A	Procedure modifier 3	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057B	Procedure modifier 4	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC058	Principal inpatient procedure code	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058A	Inpatient procedure code 2	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058B	Inpatient procedure code 3	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058C	Inpatient procedure code 4	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058D	Inpatient procedure code 5	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC058E	Inpatient procedure code 6	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058F	Inpatient procedure code 7	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058G	Inpatient procedure code 8	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058H	Inpatient procedure code 9	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058J	Inpatient procedure code 10	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058K	Inpatient procedure code 11	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058L	Inpatient procedure code 12	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058M	Inpatient procedure code 13	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC059	Date of service – From	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
MC060	Date of service - Thru	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
MC061	Quantity	Numeric	11	Yes	Count of units sent on claim line	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC062	Charges	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC062A	Allowed amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC063	Payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC064	Prepaid amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC065	Co-payment applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC066	Co-insurance applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC067	Deductible applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC067A					Do not populate; blank/null required	NA for 2023; 0.0% starting 2024
MC070	Discharge date	Date	8	Situational	Required only for institutional claims. Use 99991231 if patient has not discharged. CCYYMMDD (example: 20090605). Required only for institutional claims.	1.2%
MC076	Billing provider ID	Text	30	Yes	Identifier for the billing provider as assigned by the reporting entity.	1.2%
Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
QC05					Do not populate; blank/null required	0.0%
QC06					Do not populate; blank/null required	0.0%
QC22					Do not populate; blank/null required	0.0%
QC23					Do not populate; blank/null required	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
QC37					Do not populate; blank/null required	0.0%
QC38					Do not populate; blank/null required	0.0%
QC39					Do not populate; blank/null required	0.0%
OHLC1					Do not populate; blank/null required	0.0%
OHLC2					Do not populate; blank/null required	0.0%
MC008	Plan specific contract number	Text	30	Yes	Plan specific contract number (aka group number)	0.0%
MC201	ICD version code	Text	2	Yes	Specifies the claim's ICD version. Valid values: 9 (ICD-9) or 10 (ICD-10)	0.0%
MC202	Network	Text	1	Yes	See lookup table MC202	0.0%
MC203	Admission Type	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. Valid values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)	1.2%
MC204	Admission Source	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. See lookup table MC204	1.2%
MC205	Admitting Diagnosis	Text	8	Situational	Required for inpatient claims. ICD-10 diagnosis code for dates of service beginning 10/01/2015. Include all characters (example: E10.359), ICD-9 diagnosis code from dates of service before 10/01/2015. If ICD-9 include all digits and exclude decimal point (example: 01220). Required only for inpatient claims.	1.2%
MC206	Pay to Patient Flag	Text	1	Yes	Valid values: Y (patient was directly reimbursed), N (patient was not directly reimbursed). If unknown, default to N.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC207	Payment type	Text	2	Yes	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 07=Other See lookup table MC207 for definitions.	1.2%
MC208	NDC	Text	11	Situational	Required if MC055, MC058 or MC058A-MC058M starts with ‘J’; follow instructions in Appendix C, PC026	N/A
MC209	Flagged as SUD	Text	1	No	Optional for reporters who receive claims flagged as substance use disorder (SUD) from billing provider or flag internally 1 = Yes 0 = No	N/A
MC210	Empty field				For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_medical_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_medical_2015Q2_20150521_010101.dat

Lookup Table MC023: Discharge status

This field contains the status for the patient discharged from the hospital.

Code	Value
01	Discharged to home or self-care
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to a designated cancer center or children’s hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to the hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired place unknown
43	Discharged/transferred to a Federal hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Lookup Table MC036: Type of Service

This field is required for institutional claims and must not be populated for professional claims. The values of the second digit are situational depending on the value of the first digit.

First digit: type of facility

Code	Value
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility

Second Digit if First Digit = 1 – 6

Code	Value
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care – Level III Nursing Facility
8	Swing Beds

Second Digit if First Digit = 7

Code	Value
1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Nursing Facility Level II
7	Community Mental Health Center
9	Other

Second Digit if First Digit = 8

Code	Value
1	Hospice (Non-Hospital Based)
2	Hospice (Hospital-Based)
3	Ambulatory Surgical Center
4	Free standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
9	Other

Third Digit: claim frequency

Code	Value
1	Admit Through Discharge
2	Interim – First Claim
3	Interim – Continuing Claims
4	Interim – Last Claim
5	Late Charge Only
7	Replacement of Prior Claim
8	Void/Cancel of a Prior Claim
9	Final Claim for a Home Health Encounter

Lookup Table MC037: Place of Service

For professional claims, this field records the type of facility where the service was performed. This field should not be populated for institutional claims.

Code	Value
00	Not supplied
01	Pharmacy
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Services Freestanding Facility
06	Indian Health Services Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility

57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Lookup Table MC041P: POA flag

This field contains the inpatient present on admission (POA) flag as reported by the provider. Do not populate if not reported by the provider.

Code	Value
Y	Yes
N	No
W	Clinically undetermined
U	Information not in record
1	Diagnosis exempt from POA reporting

Lookup Table MC202: Network

This field contains a single digit indicating whether the provider was paid under a network contract.

Code	Value
1	In-network: The plan has a direct contract with the provider that made the claim.
2	National network: The plan does not have a direct contract with the provider that made the claim but paid a contracted rate through participation in a national network or reciprocal agreement with a plan operating in another state.
3	Out-of-network: The plan did not pay the provider a contracted rate.

Lookup Table MC204: Admission Source

This field contains a single character indicating source of referral for an inpatient admission. Populate this field only for institutional claims. Do not populate this field for professional claims. Use codes on the next page if MC203=4.

Code	Value if MC203 <> 4
0	ANOMALY: invalid value, if present, translate to ‘9’
1	Non-Health Care Facility Point of Origin (Physician Referral): The patient was admitted to this facility upon an order of a physician.
2	Clinic referral: The patient was admitted upon the recommendation of this facility’s clinic physician.
3	HMO referral: Reserved for National Assignment. Prior to 3/08, HMO referral: The patient was admitted upon the recommendation of a health maintenance organization (HMO) physician.
4	Transfer from a hospital (different facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
5	Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
6	Transfer from another health care facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
7	Emergency room: The patient was admitted to this facility after receiving services in this facility’s emergency room.
8	Court/law enforcement: The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency’s representative.
9	Information not available: The means by which the patient was admitted is not known.
A	Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital: patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B	Transfer from Another Home Health Agency: The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010 – See Condition Code 47)
C	Readmission to Same Home Health Agency: The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)
D	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer. The patient was admitted to this facility as a transfer from hospital inpatient within the facility resulting in a separate claim to the payer.
E	Transfer from Ambulatory Surgical Center
F	Transfer from hospice and is under a hospice plan of care or enrolled in hospice program

Code	Value if MC203 = 4
1	Normal delivery – A baby delivered without complications. ***Invalid for discharges after 12/31/2011.***
2	Premature delivery – A baby delivered with time and/or weight factors qualifying it for premature status. ***Invalid for discharges after 12/31/2011.***
3	Sick baby – A baby delivered with medical complications, other than those relating to premature status. ***Invalid for discharges after 12/31/2011.***
4	Extramural birth – A baby delivered in a non-sterile environment. ***Invalid for discharges after 12/31/2011.***
5	Born inside this hospital.
6	Born outside this hospital.
7-8	Reserved for national assignment.
9	Information not available.

Lookup Table MC207 – Payment type

Code	Value
01	Capitation is a healthcare payment in which a provider or facility is paid a fixed amount per patient for a list of services per unit of time regardless of services provided within that time
02	Fee for service is payment based on the service received by the member. Payment may be the full billed amount or less.
07	Other will include payment types not known to be capitation or fee for service

Appendix C: Pharmacy Claims file layout and dictionary

Note: This layout intends to maintain consistency with Version 1.0 of the NCPDP Uniform Healthcare Payer Data Implementation Guide.

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC001	Payer type	1	Text	Yes	N/A	N/A	See lookup table ME001 (in Eligibility file)	0.0%
PC008	Plan-specific contract number	30	Text	Yes	246	P	Plan-specific contract number (aka group number)	1.2%
PC010	Member ID	30	Text	Yes	332-CY	P	Unique identifier for member; this identifier value should be consistent between files and over time	0.0%
PC003	Insurance type/ product code	4	Text	Yes	New	P	See lookup table ME003 (in Eligibility File)	1.2%
PC021	Pharmacy NPI	15	Text	Yes	201-B1	C/P	The pharmacy's National Provider Identifier (NPI)	1.2%
PC021A	Pharmacy alternate identifier	15	Text	Situational	201-B1	P	The pharmacy's alternate identifier as assigned by the payer; required if NPI is not available	N/A
PC020	Pharmacy Name	35	Text	Yes	833-5P	P		1.2%
PC022	Pharmacy city	30	Text	Yes	728	P		1.2%
PC023	Pharmacy state	2	Text	Yes	729	P		1.2%
PC024	Pharmacy ZIP	15	Text	Yes	730	P		1.2%
PC048	Prescribing provider NPI	15	Text	Yes	411-DB	C	Identifier for provider who prescribed the medication as assigned by the reporting entity	1.2%
PC047							Do not populate; null/blank required	0.0%
PC025	Claim status	3	Text	Yes	399	P	Was claim paid, denied, CCO, or encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC026	NDC	11	Text	Yes	407-D7	C	National Drug Code (NDC)	1.2%
PC032	Date filled	8	Date	Yes	401-D1	C	Date the prescription was filled. CCYYMMDD (example: 20090624)	0.0%
PC017	Payment date	8	Date	Situational	216	P	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0.0%
PC033	Quantity dispensed	10	Numeric	Yes	442-E7	C		1.2%
PC028A	Alternate refill number	2	Numeric	Situational	403-D3	C	Required if PC028 (calculated refill number) is not available	N/A
PC034	Days supply	4	Numeric	Yes	405-D5	C	Days supply of the prescription	1.2%
PC030	Dispense as written code	1	Text	Yes	408-D8	C	See look-up table PC030	1.2%
PC028	Calculated refill number	2	Numeric	Yes	254	P	Processor's calculated refill number. If the processor is not able to calculate, the alternate refill number (PC028A) is to be used.	1.2%
PC031	Compound drug indicator	1	Numeric	Yes	406-D6	C	Indicates if this is a compound drug. Valid values: 1 (no), 2 (yes)	1.2%
PC004	Claim ID	30	Text	Yes	993-A7	P	Payer's unique claim control number	0.0%
PC036	Payment	12	Numeric	Yes	281	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC035	Charges	12	Numeric	Yes	430-DU	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC037	Ingredient cost/list price	12	Numeric	Yes	506-F6	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC039	Dispensing fee paid	12	Numeric	Yes	506-F7	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC040	Co-pay applied	12	Numeric	Yes	518-F1	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC041	Coinsurance applied	12	Numeric	Yes	572-4U	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC042	Deductible applied	12	Numeric	Yes	517-FH	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC043							Do not populate; leave blank/null	NA for 2023; 0.0% starting 2024
PC201	COB status	1	Text	Yes	337-4C		Coordination of benefits (COB) claim; count of other payment occurrences? Valid values: 0, 1, 2, 3	1.2%
PC202							For future implementation	N/A
PC203							For future implementation	N/A
PC204							For future implementation	N/A
PC205							For future implementation	N/A
PC206							For future implementation	N/A
PC207							For future implementation	N/A
PC208							For future implementation	N/A
PC209							For future implementation	N/A
PC210							For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_pharmacy_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_pharmacy_2015Q2_20150521_010101.dat

Look-up Table PC-030: Dispense as Written Code

This field contains the NCPDP Dispense as Written Code.

Code	Value
0	No product selection indicated
1	Substitution not allowed by provider
2	Substitution allowed – patient requested product dispensed
3	Substitution allowed – pharmacist selected product dispensed
4	Substitution allowed – generic drug not in stock
5	Substitution allowed – brand drug dispensed as generic
6	Override
7	Substitution not allowed – brand drug mandated by law
8	Substitution allowed – generic drug not available in marketplace
9	Other

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC001	Payer type	Text	1	Yes	See lookup table ME001 (in Eligibility file)	0.0%
DC003	Insurance Type/ Product code	Text	4	Yes	See lookup table ME003 (in Eligibility file)	0.0%
DC004	Claim ID	Text	80	Yes	Payer's unique claim identifier (i.e., claim control number) used to internally track the claim	0.0%
DC005	Service line counter	Numeric	4	Yes	Increments of 1 for each claim line	0.0%
DC008	Plan specific contract number	Text	30	Yes	Plan specific contract number (aka group number)	0.0%
DC010	Member ID	Text	30	Yes	Plan-specific unique member identifier; this identifier value should be consistent between files and over time	0.0%
DC017	Payment date	Text	8	Situational	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0.0%
DC024	Rendering provider ID	Text	30	Yes	Identifier for the rendering provider as assigned by the reporting entity	1.2%
DC037	Place of service	Text	2	Situational	See lookup table MC 037. Required only for professional claims.	1.2%
DC038	Claim status	Text	1	Yes	Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%
DC038A	Denial reason	Text	5	Situational	Report the Claim Adjustment Reason Code (CARC) that defines the reason why the claim was denied. Required when DC038 = D.	1.2 %

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC039	CDT Code	Text	5	Yes	Report the Common Dental Terminology Code for the dental procedure on the claim. CDT codes are maintained by the American Dental Association.	0.0%
DC039A	Procedure Modifier – 1	Text	2	Situational	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed.	1.2%
DC039B	Procedure Modifier – 2	Text	2	Situational	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed.	1.2%
DC040	Dental Quadrant	Text	2	Situational	Report the standard quadrant identifier when CDT code indicates procedure on 3 or more consecutive teeth. Up to four dental quadrant fields can be entered. See lookup table DC040. Blanks allowed.	0.0%
DC040A	Dental Quadrant - 2	Text	2	Situational	Report the second standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed.	1.2%
DC040B	Dental Quadrant - 3	Text	2	Situational	Report the third standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed	1.2%
DC040C	Dental Quadrant - 4	Text	2	Situational	Report the fourth standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed	1.2%
DC041	Diagnosis	Text	8	Situational	ICD-10 Diagnosis code when applicable. Required when CDT code is within the ranges of D7000-D7999 or D9220-D9221.	1.2%
DC059	Date of Service - From	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
DC060	Date of Service - Thru	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC062	Charges	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC062A	Allowed amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC063	Payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC064	Prepaid amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC065	Co-payment applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC066	Co-insurance applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC067	Deductible applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC067A	Discontinued				Do not populate; leave blank/null	NA for 2023; 0.0% starting 2024

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC076	Billing provider ID	Text	30	Yes	Identifier for the billing provider as assigned by the reporting entity.	1.2%
DC202	Network	Text	1	Yes	See lookup table MC202 (in medical claims file)	0.0%
DC207	Tooth Number/Letter (1)	Text	2	Situational	Report the tooth identifier. Required when CDT code is within the range of D2000 – D2999. Up to four tooth number/letter fields can be entered through DC207, DC209, DC211 and DC213. Blanks allowed.	0.0%
DC208	Tooth 1 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC207 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC208A	Tooth 1 - Surface 2	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208B	Tooth 1 - Surface 3	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208C	Tooth 1 - Surface 4	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208D	Tooth 1 - Surface 5	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208E	Tooth 1 - Surface 6	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC209	Tooth Number/Letter (2)	Text	2	Situational	Report the tooth identifier. Required when CDT code is within the range of D2000 – D2999. Up to four tooth number/letter fields can be entered through DC207, DC209, DC211 and DC213. Blanks allowed.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC210	Tooth 2 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC209 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC210A	Tooth 2 - Surface 2	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210B	Tooth 2 - Surface 3	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210C	Tooth 2 - Surface 4	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210D	Tooth 2 - Surface 5	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210E	Tooth 2 - Surface 6	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC211	Tooth Number/Letter (3)	Text	2	Situational	Report the third tooth identifier, if applicable on which the service was performed. See comment under DC207. Blanks allowed.	0.0%
DC212	Tooth 3 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC211 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC212A	Tooth 3 - Surface 2	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212B	Tooth 3 - Surface 3	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212C	Tooth 3 - Surface 4	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212D	Tooth 3 - Surface 5	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212E	Tooth 3 - Surface 6	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC213	Tooth Number/Letter (4)	Text	2	Situational	Report the fourth tooth identifier, if applicable on which the service was performed. See comment under DC207. Blanks allowed.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC214	Tooth 4 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC213 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC214A	Tooth 4 - Surface 2	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214B	Tooth 4 - Surface 3	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214C	Tooth 4 - Surface 4	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214D	Tooth 4 - Surface 5	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214E	Tooth 4 - Surface 6	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC299	CCO Identifier	Text	15	Situational	Populated by Medicaid only. Blank otherwise.	N/A
DC300					For future implementation	N/A
DC301					For future implementation	N/A
DC302					For future implementation	N/A
DC303					For future implementation	N/A
DC304					For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_dental_dental__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between 'dental_dental' and <quarter>.
Example: OMIP_OMIP_dental_dental__2015Q2_20150521_010101.dat

Lookup Table DC040: Dental Quadrant

This field contains the dental quadrant associated with the dental procedure.

Code	Value
00	Entire Oral Cavity
01	Maxillary arch
02	Mandibular arch
10	Maxillary (upper) right
20	Maxillary (upper) left
30	Mandibular (lower) right
40	Mandibular (lower) left
UL	Upper left
UR	Upper right
LL	Lower left
LR	Lower right

Lookup Table DC208: Tooth Surface

This field contains the tooth surface associated with the dental procedure.

Code	Value
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual/Palatal
M	Mesial
O	Occlusal

Appendix E: Provider File layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MP003	Provider ID	Text	30	Yes	Identifier for the provider as assigned by the reporting entity	1.2%
MP004	Provider Tax ID	Text	9	Yes	Tax ID of the provider (example: 1234567890)	1.2%
MP006	Provider first name	Text	25	Situational	First name of the provider (example: John); null if provider is an organization entity	1.2%
MP007	Provider middle initial	Text	1	Situational	Middle initial of the provider (example: M); null if provider is an organization entity	1.2%
MP008	Provider last name or organization	Text	100	Yes	Last name of the provider or organization entity name	1.2%
MP010	Provider specialty	Text	10	Yes	See lookup table MP010	1.2%
MP010A	Provider second specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP010B	Provider third specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP011A	Provider street address1	Text	50	Yes	First line of physical address of practice. Example: 123 Main Street	1.2%
MP011B	Provider street address2	Text	50	Situational	Required if available. Second line of physical address of practice. Example: Bldg. A, Suite 100	1.2%
MP011	Provider city	Text	30	Yes	Physical address of practice. Example: Grants Pass	1.2%
MP012	Provider state	Text	2	Yes	Physical address of practice. Example: OR	1.2%
MP013	Provider ZIP	Text	10	Yes	Physical address of practice. Examples: 97209-1234 or 97209	1.2%
MP017					Do not populate; blank/null required	0.0%
MP018	Provider NPI	Text	10	Yes	NPI of the provider (example: 1234567890)	1.2%
MP201	Primary care designation	Text	2	Yes	Provider appears in member directory or other resource as primary care provider at individual or clinic level 1 = Yes 2 = No 8 = No primary care provider directory 9 = Unknown	N/A

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MP202					For future implementation	N/A
MP203					For future implementation	N/A
MP204					For future implementation	N/A
MP205					For future implementation	N/A
MP206					For future implementation	N/A
MP207					For future implementation	N/A
MP208					For future implementation	N/A
MP209					For future implementation	N/A
MP210					For future implementation	N/A

File naming convention is

For medical:

<payer abbreviation>_<submitter abbreviation>_provider_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_provider_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_provider__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_provider’ and <quarter>.

Example: OMIP_OMIP_dental_provider__2015Q2_20150521_010101.dat

Lookup Table MP010: Provider specialty

Report the HIPAA-compliant health care provider taxonomy code. The reference code set is extensive and is published semi-annually: version 12.0 (updated effective April 1, 2012) is freely available at the National Uniform Claims Committee's web site: http://www.nucc.org/. To access the taxonomy files, point to the Code Sets menu, then point to the Taxonomy menu, and then click on either PDF (if you want a PDF file) or CSV (if you want a comma-delimited text file).

Appendix F: Subscriber Billed Premium File layout and dictionary

Note: All mandatory reporters other than CCO's are required to file this report for subscribers in fully-insured commercial and Medicare Advantage plans. PBM's that offer stand-alone prescription drug plans are also required to submit this report. Mandatory reporters do not have to file a Form APAC-1 (waiver or exception of reporting requirements), for subscribers in plans which are not required to file this report.

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
PB001	Payer type	Text	1	Yes	See lookup table ME001 (Appendix A)	0.0%
PB003	Product code	Text	4	Yes	See lookup table ME003 (Appendix A)	0.0%
PB202	Market segment	Text	2	Yes	See lookup table ME202 (Appendix A)	0.0%
PB007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber	0.0%
PB008	Premium billed month	Date	6	Yes	Month in which subscriber and related members had coverage for which subscriber was billed. CCYYMM	0.0%
PB009	Covered members in premium billed month	Numeric	3	Yes	Number of members with coverage for which subscriber was billed in the premium billed month	0.0%
PB010	Total Premium Billed for Premium Billed Month	Numeric	12	Yes	Total premium amount subscriber was billed for coverage in premium billed month. Premium billed to subscriber for premium billed month may differ from premium paid by subscriber in premium billed month if, for example, subscriber pays for more than 1 month of coverage in premium billed month. Report premium billed, not premium paid or another amount. Enter 0 if amount equals zero. Example: 15102.00	0.0%

File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_premium_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_premium_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_premium__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_premium’ and <quarter>.

Example: OMIP_OMIP_dental_premium__2015Q2_20150521_010101.dat

Appendix G: Control Totals

Note: The control totals file consists of two separate tab-delimited data files. All Mandatory Reporters other than CCOs must submit these files each quarter.

1. **Claims file control totals**

a. Claims file control totals layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
CFCT1	Payer	Text	7	Yes	Payer abbreviation See Oregon Mandatory Reporters and Abbreviations table on website: https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/2020-APAC-mandatory-reporters-abbreviations.pdf	0.0%
CFCT2	File	Text	10	Yes	Valid values: medical, pharmacy, dental, enrollment, provider, and premium	0.0%
CFCT3	Data_ Rows	Numeric	8	Yes	Count of data rows in the submitted file	0.0%
CFCT4	Amt_ Billed	Numeric	14	Yes	Sum of MC062 (medical), PC035 (pharmacy), DC062 (dental), or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider	0.1%
CFCT5	Amt_ Paid /Premium Billed	Numeric	14	Yes	Sum of MC063 (medical), PC036 (pharmacy), DC063 (dental), or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider.	0.1%

b. Claims file control totals example

Example when all file types are submitted

Payer	File	Data_Rows	Amt_Billed	Amt_Paid
OMIP	Medical	12345678	123456789.12	123456789.12
OMIP	Pharmacy	12345678	123456789.12	123456789.12
OMIP	Enrollment	12345678		
OMIP	Provider	123456		
OMIP	Premium	12345	123456789.12	
OMIP	Dental	12345	123456789.12	123456789.12

Example when only some file types are submitted

Payer	File	Data_Rows	Amt_Billed	Amt_Paid
OMIP	Medical	0	0	0
OMIP	Pharmacy	12345678	123456789.12	123456789.12
OMIP	Enrollment	12345678		
OMIP	Provider	0		
OMIP	Premium	12345	123456789.12	
OMIP	Dental	0	0	0

c. File naming convention is:

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_totals_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_totals_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_totals__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscrore between ‘dental_totals’ and <quarter>.
Example: OMIP_OMIP_dental_totals__2015Q2_20150521_010101.dat

2. **Member months control totals**

   a. **Member months control totals layout and dictionary**

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MMCT1	Payer	Text	7	Yes	Payer abbreviation. See Oregon Mandatory Reporters and Abbreviations table on website: www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/2020-APAC-mandatory-reporters-abbreviations.pdf.	0.0%
MMCT2	Method	Text	1	No	Placeholder for future compatibility	N/A
MMCT3	Month	Date	6	Yes	CCYYMM	0.0%
MMCT4	Medical Members	Numeric	8	Situational	Count of members with medical coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no medical members.	0.1%
MMCT5	Pharmacy Members	Numeric	8	Situational	Count of members with pharmacy coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no pharmacy members.	0.1%
MMCT6	Dental Members	Numeric	8	Situational	Count of members with dental coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no dental members.	0.1%

b. Member months control totals example

Payer	Method	Month	Medical_Members	Pharmacy_Members	Dental_Members
OMIP		201001	12345678	12345678	0
OMIP		201002	12345678	12345678	0
OMIP		201003	12345678	12345678	0
OMIP		201004	12345678	12345678	0
OMIP		201005	12345678	12345678	0
OMIP		201006	12345678	12345678	0
OMIP		201007	12345678	12345678	0
OMIP		201008	12345678	12345678	0
OMIP		201009	12345678	12345678	0
OMIP		201010	12345678	12345678	0
OMIP		201011	12345678	12345678	0
OMIP		201012	12345678	12345678	0

c. File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_membership_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_membership_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_membership__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_membership’ and <quarter>.

Example: OMIP_OMIP_dental_membership__2015Q2_20150521_010101.dat

AMEND: 409-025-0140

RULE SUMMARY: Terminology update

CHANGES TO RULE:

409-025-0140
Waivers, Exemptions and Ex~~cept~~tensions ¶

(1) The Authority may grant a waiver, deadline extension, or exemption to the reporting and validation requirements.¶
(2) A mandatory reporter is required by law and rule to submit all required data files no later than the submission deadline and at sufficient quality to meet or exceed the published validation requirements. Mandatory reporters shall notify the Authority of their inability to meet any requirement within the timeline stated in rule or incorporated by reference.¶
(3) A mandatory reporter may request a waiver of reporting requirements. The request shall be submitted 60 calendar days prior to the applicable reporting deadline using the APAC-1a form.¶
(a) Mandatory reporters may request a waiver of reporting for the following reasons:¶
(A) A mandatory reporter who is a carrier or a third party administrator and, either due to decrease in covered lives or covered lives excluded as reporting to the federal Department of Labor under the Employment Retirement Income Security Act (ERISA), has fewer than 5,000 covered lives in Oregon to report;¶
(B) A mandatory reporter does not bill subscribers for premiums (Appendix F only);¶
(C) A mandatory reporter has no contracts sitused in Oregon for Appendices 1 and 2 under OAR 409-025-0125; or¶
(D) A mandatory reporter whose data is reported by another affiliated or contracted Oregon All Payer All Claims mandatory reporter if submitting files would create duplicate claims.¶
(b) A mandatory reporter who intends to withhold data under OAR 409-025-0110(8) must request a waiver and receive approval prior to withholding data.¶
(c) Mandatory reporters other than carriers and third party administrators may request a waiver of reporting based on the number of covered lives potentially reported. The Authority may approve a waiver if it determines the burden of reporting outweighs the value of the data in understanding services and costs in Oregon.¶
(d) Waivers are required only for the file types identified for the mandatory reporter type under OAR 409-025-0120 and OAR 409-025-0125.¶
(e) The Authority shall approve or deny the waiver request and provide written notification to the requestor within 14 calendar days of receipt of the request.¶
(f) Waivers of reporting are approved for one calendar year and may cover partial reporting years. Waivers must be requested each year that the reason for waiver continues to be in effect.¶
(4) A mandatory reporter may request a deadline extension for initial submission or correction of validation errors of required files. The request shall be submitted within the APAC vendor's reporting portal at least 14 calendar days prior to the applicable reporting deadline.¶
(a) The mandatory reporter must explain why sufficient data or resources are not allocated to reporting to meet the published expectations for timing and data quality. The request must include the organization's plan to mitigate future incidents and whether the plan has been approved and resources allocated to accomplish the activity within the stated timeline.¶
(b) The Authority shall approve or deny the extension request and provide notification to the requestor within seven (7) calendar days of receipt of the request.¶
(c) Extensions are approved for one reporting period. Failure to submit acceptable files at the end of the extension may result in a civil penalty under OAR 409-025-0150.¶
(5) A mandatory reporter may request an exemption for validation rules identified as Exemption' level. The request must be submitted through the APAC vendor's reporting portal and cannot be submitted in advance of validation failure.¶
(a) Specific review of the failed validation results is required prior to requesting an exemption. Mandatory reporters must explain why the validation rule cannot be met and should not rely on receipt of poor-quality data as a reason for exemption. Requests that are not specific to the validation rule and data file submitted will be denied.¶
(b) The Authority shall approve or deny the exemption request and provide notification to the requestor through the APAC vendor's reporting portal within seven (7) calendar days of receipt of the request.¶
(c) Exemptions are approved for a single submission or up to one calendar year. Failure to submit acceptable files based on approved exemptions may result in a civil penalty under OAR 409-025-0150.¶
(6) If the Authority denies the request, the requestor may appeal the denial by requesting a contested case

hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS Chapter 183 and the Attorney General's Uniform and Model rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the waiver, exemption or ex~~cept~~tension.
Statutory/Other Authority: ORS 442.~~466~~373
Statutes/Other Implemented: ORS 442.~~464,~~373, ORS 442.~~466~~372

AMEND: 409-025-0160

RULE SUMMARY: Changing the public use file to protect member and subscriber confidentiality and dropping confidentiality for provider and facility.

CHANGES TO RULE:

409-025-0160
Data Access and Release ¶

(1) The Authority shall comply with all relevant state and federal data privacy, security, and antitrust regulations, including The Health Insurance Portability and Accountability Act (HIPAA), when sharing APAC data.¶
(2) The Authority may collect payment to recoup costs when APAC data requests are fulfilled.¶
(3) The Authority shall provide a public use data set, which shall include de-identified member health information, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes.¶
(a) The Authority shall maintain a list of data elements ~~that may be~~ included in APAC public use data sets.¶
(b) Requestors seeking access to an APAC public use data set shall complete a P~~re-Application for APAC Data Files (APAC-2) and submit full payment~~ublic Use Data File Application (APAC-2). Payment is required as follows:¶
(A) Actual cost with a maximum cost of $500 per data year for Medical Claims;¶
(B) Actual cost with a maximum cost of $500 per data year for Pharmacy Claims;¶
(C) Actual cost with a maximum cost of $500 per data year for Dental Claims; and¶
(D) Enrollment file requested in conjunction with Medical, Pharmacy or Dental Claims will be provided without additional charge.¶
(c) The Authority may approve or deny the completed request and provide written notification to the requestor within 30 calendar days of receipt of the request.¶
(d) The Authority shall deny the completed request for reasons which include, but are not limited to:¶
(A) Requestor or any person who will have access to the data has previously violated a data use agreement with the Authority.¶
(B) The Authority finds that the specific details of the request do not sufficiently explain the proposed use.¶
(C) The Authority finds that the specific details of the request violate any state or federal rule, regulation, or statute.¶
(D) Full payment is not included with the application or received within thirty (30) days of invoicing.¶
(e) If the Authority denies the P~~re-~~ublic Use Application ~~for APAC Data Files~~ (APAC-2):¶
(A) The Authority shall provide written notification stating the reason for the denial and process return of payment; and¶
(B) The requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS chapter 183 and the Attorney General's Uniform and Model Rules of Procedure, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove that the Authority unreasonably denied the application.¶
(f) The public use data sets may not be used to identify any individual, including ~~but not limited to patients, physicians, and other health care provid~~members or subscribers. The requestor may not use outside information to attempt to ascertain the identity of individuals who are the subject of public use data sets.¶
(g) Provider information will be reviewed for information that may be considered personally identifiable information. ¶
(A) If a taxpayer identification number is determined to be a social security number, such information shall not be released. ¶
(B) Information already available to the public including published licensing data or public-facing data from the National Plan & Provider Enumeration System shall not be considered personally identifiable information.¶
(4) The Authority shall provide limited data sets, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes. Limited data sets may include protected health information.¶
(a) The Authority shall maintain a list of data elements that may be included in APAC limited data sets if approved for a specific request.¶
(b) APAC limited data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operations.¶
(c) Requestors seeking access to APAC limited data sets shall complete the Application for APAC Data Files (APAC-3).¶
(d) Requestors must identify each data element requested and explain the use of the data element within the description of activity in the application. The Authority will determine which data elements will be released after review under HIPAA and other applicable laws, regulations, and rules.¶
(e) The Authority shall determine the hours required to complete the data request and inform the requestor of the

cost of the resulting data set.¶
(5) The Authority shall provide data, in compliance with applicable Authority policies and state and federal rules, regulations and statutes, to Oregon state agencies and local public health authorities. Use is limited to activities required to meet the agency's duties as authorized by Oregon law.¶
(a) Agency-use data sets may include protected health information.¶
(b) Requestors seeking access to APAC agency data sets shall complete the Application for Agency Data Files and must explain use of each data element requested.¶
(c) Agency requests will be posted on the Data Review Committee for a minimum of two weeks to support transparency in data use.¶
(6) Requests for public use data set or limited data sets must be made using the form and manner prescribed by the Authority that is available on the agency's website. The form shall collect sufficient information to evaluate any request for APAC data.¶
(7) Requestors who receive a limited data set must maintain Institutional Review Board (IRB) approval, if required for the data use agreement, throughout the span of authorized use of the data and until the data is destroyed. Requestors must submit updated documentation authorizing continued activity prior to the expiration of the previous authorization.¶
(8) Requesters who receive a limited data set must submit an amendment to the Authority when there is a change in the proposed use of the data within the scope of the original data request.¶
(a) Requestors shall file such an amendment when any of the following is anticipated:¶
(A) A change in persons accessing the data;¶
(B) Additional data elements are requested;¶
(C) Additional years of data are requested;¶
(D) Any change in the use of the data including linking or the addition of research questions; or¶
(E) Any change in research protocol, regardless of approval by an IRB.¶
(b) Changes or additions to use that are outside of the scope of the original data request will not be approved.¶
(c) Requestors may not implement any change related to access or use of data prior to receiving approval from the Authority.¶
(d) Changes in data elements, data use or research protocol must be reviewed by the Data Review Committee (DRC) described in OAR 409-025-0190. In addition, a recommendation by the DRC may be sought for additional years of data or new project staff for limited data sets the Authority determines to include vulnerable populations.¶
(e) The Authority shall review for completeness all applications and provide requestors written notification of completeness within 30 calendar days of receipt of the request. If the Authority determines that the application is incomplete, the requestor shall have 30 calendar days from notification of incompleteness to complete the application. Incomplete applications that are not completed shall be discarded without further notification to the requestor.
Statutory/Other Authority: ORS 442.373
Statutes/Other Implemented: ORS 442.373, ORS 442.372